U.S. Department of Labor

Office of Administrative Law Judges
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Date: November 29, 2000

Case No.: 2000-BLA-0572

In the Matter of:

MARY ANN PERRY, Surviving Spouse
of OWEN T. PERRY,
Claimant

v.

ISLAND CREEK COAL CO.,
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:[1]

Joseph H. Kelley, Esq.
For the Claimant

William S. Mattingly, Esq.
For the Employer

BEFORE: Robert L. Hillyard
Administrative Law Judge

DECISION AND ORDER - DENIAL OF BENEFITS

This proceeding arises from a claim filed by Mary Ann Perry for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901, *et seq.*, as amended (Act). In accordance with the Act, and the regulations issued thereunder, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs (OWCP). The regulations issued under the Act are located in Title 20 of the Code of Federal

[1] The Director, Office of Workers' Compensation Programs, was not represented at the hearing.

Regulations, and regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

Benefits under the Act are awarded to persons who are totally disabled due to pneumoconiosis within the meaning of the Act. Survivors of persons who were totally disabled at their times of death or whose deaths were caused by pneumoconiosis also may recover benefits. Pneumoconiosis is a dust disease of the lungs arising out of coal mine employment and is commonly known as black lung disease.

A formal hearing was held in Madisonville, Kentucky on August 29, 2000. Each of the parties was afforded full opportunity to present evidence and argument at the hearing as provided in the Act and the regulations thereunder. The findings and conclusions that follow are based on my observation of the demeanor and appearance of the witness who testified at the hearing and a careful analysis of the entire record in light of the arguments of the parties, applicable statutory provisions, regulations, and pertinent case law.

I. PROCEDURAL HISTORY

The Claimant, Mary Ann Perry, filed a claim for benefits under the Act on April 8, 1998, as surviving spouse of Owen T. Perry (DX 1).[2] The Office of Workers' Compensation Programs (OWCP) denied the claim on August 4, 1998 (DX 12). The Claimant appealed by letter dated August 19, 1998 (DX 14). Following the submission of additional evidence, OWCP denied the claim on December 23, 1998 (DX 24). The Claimant appealed on December 30, 1998, and OWCP again denied the claim on April 30, 1999 (DX 26, 32). By letter dated May 10, 1999, the Claimant requested a hearing before the Office of Administrative Law Judges (DX 33). The District Director, on November 16, 1999, issued a Decision and Order Memorandum of Conference denying benefits (DX 42). The Director found that although pneumoconiosis arising out of coal mine employment was established, death due to pneumoconiosis was not. The Employer, Island Creek Coal Company, filed a Request for Reconsideration on November 19, 1999 with respect to the Director's finding of pneumoconiosis arising out of coal mine employment, and on December 2, 1999 the Claimant again appealed the denial of benefits (DX 39–40). The case was forwarded to the Office of Administrative Law Judges on March 13, 2000 (DX 45).

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[2] In this Decision and Order, "DX" refers to the Director's Exhibits, "CX" refers to the Claimant's Exhibits, "EX" refers to the Employer's Exhibits, and "Tr." refers to the transcript of the August 29, 2000 hearing.

The Miner, Owen T. Perry, filed a claim for benefits on June 12, 1978 (DX 43, p. 414). The undersigned Administrative Law Judge awarded benefits by Decision and Order dated September 26, 1983 (DX 43, p. 80). On appeal by the Employer, the Decision was reversed by Decision and Order of the Benefits Review Board (Board) dated February 28, 1986 (DX 43, p. 1). No appeal was taken and the Decision became final.

II. ISSUES[3]

The specific issues presented for resolution as noted on Form CM-1025 are as follows:

1. Whether the Miner had pneumoconiosis as defined in the Act and the regulations;

2. Whether the Miner's pneumoconiosis arose out of coal mine employment; and,

3. Whether the Miner's death was due to pneumoconiosis.

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

Owen T. Perry was born on October 23, 1921, and died on March 27, 1990, at the age of sixty-eight (DX 1, 9). He married Mary Ann (Moore) Perry on December 3, 1946 (DX 7). Mrs. Perry has not remarried since his death and is the surviving spouse of the Miner (Tr. 17).

Length of Coal Mine Employment/Responsible Operator

The parties stipulated to forty-six years of coal mine employment (Tr. 14–15). This stipulation is supported by the evidence, including a letter from Island Creek Coal Company. I find that the Miner had forty-six years of coal mine employment.

Island Creek Coal Company has been designated as the Responsible Operator. This is undisputed by the parties and is supported by the evidence. Accordingly, I find that Island Creek Coal Company is properly designated as the Responsible Operator.

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[3] At the hearing, the parties stipulated that total disability is not an issue in this case as this is a survivor's claim (Tr. 13).

IV. MEDICAL EVIDENCE

Medical evidence as listed in the September 26, 1983 Decision and Order is incorporated herein by reference. Evidence submitted subsequent to that date is listed below. The record also contains additional reports and x-ray interpretations which pertain to the Claimant's heart problems. As these records were not made with the purpose of diagnosing pneumoconiosis or addressing the issue of death due to pneumoconiosis, they will not be discussed further in this Decision.

X-ray Studies

	Date	Exhibit	Doctor	Reading	Standards
1.	03/26/90	EX 5	Jarboe B reader[4]	1/1 q,q	Fair
2.	03/26/90	EX 4	Morgan B reader	1/1 q,q	Fair
3.	03/26/90	EX 4	Branscomb B reader	No pneumo. Unreadable	
4.	03/26/90	DX 27	Wiot B reader Board cert.[5]	No pneumo.	Good
5.	03/26/90	DX 29	Perme B reader Board cert.	No pneumo.	Fair
6.	03/26/90	DX 30	Spitz B reader	No pneumo.	Fair

[4] A B reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services.

[5] A Board-certified Radiologist is a physician who is certified in Radiology or Diagnostic Roentgenology by the American Board of Radiology or the American Osteopathic Association. *See* § 718.202(a)(ii)(C).

			Board cert.			
7.	03/26/90	DX 34	Scott B reader Board cert.	No pneumo.	Good	
8.	08/03/83	DX 22	Givens	Bilateral fibrosis		Not stated
9.	07/31/81	EX 4	Morgan B reader	1/1 q,q		Fair

	Date	Exhibit	Doctor	Reading	Standards
10.	07/31/81	EX 4	Branscomb B reader	2/1 p,q	Fair
11.	07/31/81	EX 5	Jarboe B reader	1/2 q,q	Fair

Pulmonary Function Studies

	Date	Exhibit	Doctor	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Standards
1.	07/31/81	DX 11	Simpao	59/66"	2.94	3.47	112	85%	Tracings included

Arterial Blood Gas Studies

	Date	Exhibit	pCO_2	pO_2
1.	07/31/81	DX 11	33.4	77.2

Death Certificate

The Certificate of Death, signed by Dr. Robert N. Hurst, III, lists the date of death as March 27, 1990 and the immediate cause of death as acute myocardial infarction. It also lists "arteriosclerotic heart disease – CHF" as an underlying cause of death and "pneumoconiosis; diabetes; pacemaker" as other significant conditions contributing to death but not resulting in the underlying cause of death (DX 9).

Narrative Medical Evidence

1. Dr. George L. Zaldivar, who is a B reader and is Board certified in Internal Medicine, Critical Care Medicine, and Pulmonology, issued a consultative report dated August 3, 2000 based on his review of numerous medical records, including the Death Certificate, reports by Drs. Wong, Getty, Simpao, Hearne, Jivrajka, West, and Givens, along with objective test results and interpretations of x-rays dated between 1979 and 1990. Dr. Zaldivar noted that the Miner had symptoms of severe coronary artery disease beginning in 1979 when he first presented himself for black lung evaluation. He opined that the evidence is insufficient to justify a diagnosis of pneumoconiosis or that the Miner suffered from any pulmonary impairment. The Miner was not totally disabled from coal mine

employment from a pulmonary standpoint prior to his death. He stated that because the Miner did not suffer from pneumoconiosis, it could not have caused his death. In addition, the Miner "died a cardiac death due to arteriosclerotic vascular disease which caused him to have three heart attacks, the last one of which was terminal." Dr. Zaldivar concluded that pneumoconiosis did not contribute to the Miner's death and he "would have died when and as he did even if he had never worked in the coal mines" (EX 8).

2. a. Dr. Thomas M. Jarboe, a B reader and Board-certified Internist and Pulmonologist, issued a consultative report dated August 3, 2000 based on his review of numerous medical records, including the Death Certificate, reports by Drs. Wong, Getty, Simpao, Hearne, Jivrajka, West, and Givens, along with objective test results and interpretations of x-rays dated between 1979 and 1990. He found evidence of pneumoconiosis on x-ray but no evidence of a respiratory impairment based on normal spirometry and blood gas testing. Dr. Jarboe does not believe that pneumoconiosis "had any significant effect on this man's course prior to death" because "to have done so, the pneumoconiosis would have to have affected his ventilatory function or gas exchange." He noted that Dr. Givens opined that pneumoconiosis contributed to the Miner's death, however, there is no indication that the Miner was treated with medication for any respiratory problem. He stated that the Miner's symptoms were consistent with cardiac problems. Dr. Jarboe concluded that pneumoconiosis did not cause, contribute to, or hasten the Miner's death (EX 6).

b. Dr. Jarboe was deposed on August 14, 2000, at which time he recounted what was stated in his written report. He opined that the Miner suffered from simple pneumoconiosis based on x-ray. He noted that simple pneumoconiosis "very unusually causes any impairment" and opined that the Miner did not suffer from a pulmonary impairment. Dr. Jarboe based his finding on spirometry and normal blood gases. He concluded that pneumoconiosis did not cause or hasten the Miner's death based on normal pulmonary function and arterial blood gas testing. He disagreed with Dr. Givens' finding of COPD because there is no test showing that the Miner suffered from COPD. Dr. Jarboe noted that congestive heart failure can cause air flow obstruction and that patients with congestive heart failure could be confused with a patient who has COPD. He opined that the Miner died from cardiac disease and that there is nothing in the record showing any causal connection between his heart disease and exposure to coal dust (EX 9).

3. a. Dr. Ben V. Branscomb, who is a B reader, a Board-certified Internist, and a Professor Emeritus at the University of Alabama at Birmingham, issued a consultative report dated May 11, 2000 based on his review of numerous medical records, including reports by Drs. Getty, Givens, Simpao, Hearne, Casey, and Jivrajka, as well as objective test results and x-ray interpretations dated between 1979 and 1990. Dr. Branscomb opined that the Miner had a diffuse interstitial pulmonary disease which represents coal workers' pneumoconiosis. He found no objective evidence of a pulmonary impairment, however, and noted that physicians who treated him did not find any continuing pulmonary disease problem. Dr. Branscomb does not believe that the Miner was totally disabled from a respiratory standpoint and that pneumoconiosis "had no impact whatsoever on the development, progression, and events leading to death from the cardiac disease." The Miner would have died in the same way and at the same time "had he never stepped foot in a coal mine." Dr. Branscomb noted a strong family history of heart disease coupled with longstanding diabetes mellitus. He could not determine if smoking was a factor from the available records (EX 3).

b. Dr. Branscomb was deposed on August 15, 2000, at which time he reiterated much of what was stated in his written report. Dr. Branscomb opined that the Miner suffered from pneumoconiosis based on x-ray but that he did not suffer from any pulmonary impairment based on pulmonary function and arterial blood gas testing. He also stated that the Miner's symptoms reflected heart disease and not a pulmonary impairment. Dr. Branscomb noted that Dr. Givens did not treat the Miner for pneumoconiosis despite his finding that the Miner suffered from pneumoconiosis. He does not agree with Dr. Givens' finding that the Miner suffered from cardiac disease which was complicated by a pulmonary condition. Dr. Branscomb stated that the Miner had severe cardiac problems for many years and that he died as a result of this condition. He noted that although Dr. Givens said that a "pulmonary condition" complicated the cardiac condition, he did not say that "pneumoconiosis" complicated the condition. Dr. Branscomb stated that the Miner "had a severe pulmonary problem, all right, and that was left ventricular failure." He believes that Dr. Givens was referring to the left ventricular failure when he referred to a "pulmonary condition." Dr. Branscomb does not believe that pneumoconiosis contributed to the Miner's death based on normal pulmonary function and blood gases and no evidence of cor pulmonale. He also noted that patients with the Miner's level of heart failure generally have the Miner's level of complications but that patients with

the Miner's level of pneumoconiosis do not have such a degree of complications (EX 10).

4. a. Dr. A. Dahhan, who is a B reader and a Board-certified Internist and Pulmonologist, issued a consultative report dated June 22, 1999 based on his review of various medical records, including the Death Certificate, reports by Dr. Givens and x-ray interpretations by Drs. Spitz, Perme, and Wiot. Dr. Dahhan concluded that there is insufficient objective evidence to justify a diagnosis of pneumoconiosis. He noted negative x-ray readings and that the Miner did not take any pulmonary medication. Dr. Dahhan opined that the Miner was totally disabled at the time of his death because of congestive heart failure and suffered no pulmonary disability. The Miner's death was due to a heart attack complicating a known previous heart attack and coronary artery disease, conditions of the public at large. Dr. Dahhan concluded that the Miner's death was not caused, contributed to, or hastened by pneumoconiosis. He noted that the Miner's heart failure was on the left side, a condition not seen in patients who develop heart failure secondary to coal dust exposure (DX 37).

b. Dr. Dahhan issued a supplemental report dated April 7, 2000 based on his review of the evidence listed in his June 1999 report, as well as records regarding the Miner's cardiac problems in 1982 and 1983. He noted that the data from the earlier years showed radiological findings consistent with pneumoconiosis, however, the more recent evidence is not consistent with pneumoconiosis. He concluded that if the Miner had simple pneumoconiosis, "he did not have any finding to indicate any physiological respiratory impairment or disability since all of his pulmonary function and arterial blood gas studies showed normal findings." Since the Miner had no evidence of functional respiratory impairment, Dr. Dahhan stated that even if he did have pneumoconiosis, it did not contribute to the Miner's death, which was due to a heart attack and would have occurred regardless of the Miner's coal dust exposure (EX 1).

5. a. Dr. W.K.C. Morgan issued a consultative report dated July 16, 1999 based on his review of various medical records including the Death Certificate, reports by Dr. Givens and interpretations of x-rays by Drs. Spitz, Perme, and Wiot. Dr. Morgan opined that the Miner died as a result of myocardial infarction, "which had no relationship to his former occupation of coal mining, and coal dust played no role in his death." He noted a strong family history of cardiac disease. Dr. Morgan also noted that the Miner suffered shortness of breath, which he

opined was related to congestive heart failure. “There is therefore no need to invoke any lung disease as a cause of his problem. Moreover, there is absolutely no mention of coal workers’ pneumoconiosis in the x-rays that were taken and it was said to be absent in 1990 at the time of his death.” Dr. Morgan stated that it could be possible that the Miner “had some minimal CWP in his lungs” but it can be assumed that it was so minimal that it did not show up on x-ray and was not associated with any respiratory symptoms. He does not think the Miner suffered from any respiratory disease as evidenced by normal blood gas testing. Dr. Morgan concluded that neither pneumoconiosis nor exposure to coal dust contributed to or hastened the Miner’s death. Dr. Morgan is a B reader and an Emeritus Professor of Medicine at the University of Ontario (DX 36; EX 11).

b. Dr. Morgan issued a supplemental report dated April 17, 2000 based on the evidence reviewed in his earlier report, as well as medical records during the 1980's. Dr. Morgan noted that the Miner worked long enough in the mines to have developed pneumoconiosis and the earlier x-ray suggested its presence; thus, he thinks “it probable that Mr. Perry did indeed have CWP.” He stated that it is possible that the congestive heart failure noted on x-ray obscured the nodules which characterize pneumoconiosis, explaining why Dr. Spitz did not find evidence of the disease on the March 26, 1990 x-ray. Dr. Morgan noted that the Miner gave a variety of different smoking histories. He concluded that the Miner likely had pneumoconiosis, however, the cause of death was heart disease. “It is quite clear that Mr. Perry was disabled for two to three years with congestive failure and heart disease and that his disability developed after 1983 and was clearly a consequence of his heart disease and was unrelated to his former job as a miner.” Dr. Morgan opined that coal dust made no contribution to the Miner’s disability or demise (EX 2).

c. Dr. Morgan was deposed on August 18, 2000, at which time he recounted what was stated in his earlier written reports. He found evidence of pneumoconiosis on the July 31, 1981 and March 26, 1990 x-ray films. Dr. Morgan found no evidence of a pulmonary impairment, however, based on pulmonary function and arterial blood gas testing. He stated that any pulmonary symptoms suffered by the Miner were due to his heart problems. Dr. Morgan noted that the Miner stated that his health “had always been good” until he was hospitalized for myocardial infarction in 1982, that the Miner did not take any medication for pulmonary impairment, and that the Miner did not complain of cough or sputum after ceasing coal mine employment.

He attributed the Miner's death to heart disease and disagreed with Dr. Givens that the Miner's heart condition was aggravated by his pulmonary condition. The Miner's death was not caused or hastened by pneumoconiosis (EX 11).

6. a. Dr. Gary D. Givens stated in a letter dated July 18, 2000 that the Miner had chronic obstructive pulmonary disease which hastened his death. "There is no question that the addition of pulmonary disease dramatically increases the workload on the heart which exacerbates cor pulmonale, congestive heart failure, and more rapid weakening of the myocardium." He noted that no pulmonary function studies were performed in the latter years of the Miner's life to ascertain the extent of his pulmonary disease and that all of his office notes pertain to the Miner's cardiac disease and diabetes "because these conditions were the over-riding disabilities" (CX 1).

b. Dr. Givens signed a letter dated October 21, 1998 which states that he treated the Miner from October 27, 1971 until his death in 1990. "Throughout that time he was known to have and was treated for pneumoconiosis." Dr. Givens stated that the Miner had frequent respiratory infections and increasing dyspnea with exertion, as well as severe cardiac disease. "The work load on his heart was aggravated by his pulmonary condition. In my opinion, the pneumoconiosis was a contributing factor in his death."

c. Attached to Dr. Given's letter are records pertaining to the Claimant's two periods of hospitalization at Muhlenberg Community Hospital between February 3, 1990 and March 27, 1990. These records show that the Miner was admitted on February 3, 1990 with complaints of shortness of breath and chest pain radiating from the left sternum to the right. Dr. Givens noted frequent nonproductive cough, chills, fever, and weakness. Films of the chest revealed a pacemaker and congestive heart failure. EKG's revealed left ventricular hypertrophy and poor R wave progression, compatible with old anterior injury. A physical examination and blood gas studies were also performed. The congestive heart failure improved and the Miner was discharged stable on February 12, 1990, but with a "poor prognosis." Dr. Givens stated the discharge diagnoses as: (1) congestive heart failure, improved; (2) arteriosclerotic heart disease with cardio-megaly; (3) common duct stone, suspected, not proven; (4) mild adult onset diabetes mellitus; and, (5) renal insufficiency.

The Miner was admitted again to Muhlenberg Community Hospital on March 21, 1990 with complaints of shortness of breath and chest pain. A history of congestive heart failure and pneumoconiosis was noted, as well as a history of myocardial infarctions, pacemaker placement, and diabetes. Dr. Givens performed a physical examination and an arterial blood gas study and interpreted an x-ray and EKG. X-ray's initially showed increasing congestive heart failure but x-rays taken on March 24 and 26, 1990 revealed only chronic changes but with no congestive heart failure. EKG's were "grossly abnormal." Dr. Givens noted that the Miner appeared to be doing well, was asymptomatic the day prior to his death, and requested to be discharged. He suddenly developed acute chest pain, however, and died on March 27, 1990. Dr. Givens stated in the Discharge Summary that death was due to: (1) acute myocardial infarction with cardiac arrest; (2) coal workers' pneumoconiosis; and, (3) adult onset diabetes mellitus (DX 22).

V. DISCUSSION AND APPLICABLE LAW

Because the Claimant filed this claim after March 31, 1980, it must be adjudicated under the regulations at 20 C.F.R. Part 718. These regulations provide that benefits are provided to eligible survivors of a miner whose death was due to pneumoconiosis. *See* § 718.205(a). In a Part 718 survivor's claim, the Administrative Law Judge must make a threshold determination of the existence of pneumoconiosis under 20 C.F.R. § 718.202(a) prior to considering whether the miner's death was due to the disease under § 718.205. *See Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85, 1-88 (1993).

Under § 718.202(a)(1), a claimant may prove that the miner had pneumoconiosis on the basis of x-ray evidence. The record contains twenty-nine interpretations of eleven x-rays.[6] Nineteen interpre-tations are positive, five are negative and five interpretations were not made with the purpose of diagnosing pneumoconiosis. Four of the positive interpretations are by physicians who are both B readers and Board-certified Radiologists, six are by physicians who are B readers only, three are by physicians who are Board-certified Radiologists only, and six are by physicians who lack any special radiographical qualifications. Four of the negative interpretations are by dually qualified physicians, and one is

[6] Eighteen of those interpretations are of x-rays dated between August 15, 1979 and March 7, 1983 and are listed in the prior Decision and Order dated September 26, 1983.

by a physician who is a B reader only. Interpretations by B readers are entitled to greater weight because of their expertise and proficiency in classifying x-rays. *See Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985); *Vance v. Eastern Associated Coal Corp.*, 8 B.L.R. 1-68 (1985). A doctor who is a B reader as well as a Board-certified Radiologist may be credited over a physician who is only a B reader. *See Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984). The x-ray evidence of record was generated over two time periods: 1990 and the 1980's. Drs. Jarboe and Morgan, both B readers, gave positive readings to both the March 26, 1990 and July 31, 1981 x-rays. Dr. Branscomb, a B reader, found the March 26, 2000 x-ray to be unreadable and that it showed no evidence of pneumoconiosis. He gave the July 31, 1981 x-ray a 2/1 reading, however, and opined in his May 11, 2000 report and at the August 15, 2000 deposition that the Miner suffered from pneumoconiosis. Drs. Wiot, Perme, Spitz, and Scott, all of whom are dually qualified physicians, found evidence of congestive heart failure but no evidence of pneumoconiosis based on the May 26, 1990 x-ray. The remaining interpretations are positive for pneumoconiosis.

I find that the x-ray evidence establishes the existence of pneumoconiosis. In addition to positive interpretations by four dually qualified physicians, six B readers and three Board-certified Radiologists gave positive x-ray readings. Six physicians with no special qualifications also gave positive readings. The only interpretation supporting the negative readings of the dually qualified physicians is by Dr. Branscomb who, as noted, gave inconsistent x-ray interpretations and opinions with respect to the presence of pneumoconiosis.

The Claimant must prove that the Miner’s pneumoconiosis arose at least in part out of coal mine employment. *See* 20 C.F.R. § 718.203(a). As the existence of pneumoconiosis and at least ten years of coal mine employment have been established, the Claimant is entitled to the rebuttable presumption contained in § 718.203(b). As there is no evidence to rebut the presumption, I find that the Miner’s pneumoconiosis arose out of his coal mine employment.

In order to establish entitlement to benefits, the Claimant must show that the Miner’s death was due to pneumoconiosis. Subsection 718.205(c) applies to survivor’s claims filed on or after January 1, 1982 and provides that death will be due to pneumoconiosis if any of the following criteria are met:

(1) Where competent medical evidence established that the miner's death was due to pneumoconiosis, or

(2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or

(3) Where the presumption set forth at § 718.304 [complicated pneumoconiosis] is applicable.

The United States Court of Appeals for the Sixth Circuit has held that "pneumoconiosis is a substantially contributing cause or factor leading to the miner's death if it serves to hasten that death in any way." *Griffith v. Director, OWCP*, 49 F.3d 184, 186 (6th Cir. 1995); *see also, Brown v. Rock Creek Mining Co., Inc.,* 996 F.2d 812, 816 (6th Cir. 1993).

Seven physicians gave opinions regarding the cause of the Miner's death. Drs. Zaldivar, Jarboe, Morgan, Branscomb, and Dahhan found that pneumoconiosis did not cause or hasten his death. Dr. Hurst signed the Death Certificate and listed pneumoconiosis as a significant condition contributing to but not resulting in the underlying cause of death. Dr. Givens opined that pneumoconiosis was a contributing factor in the Miners' death.

Dr. Hurst signed the Certificate of Death, which gives the immediate cause of death as acute myocardial infarction. It also lists "arteriosclerotic heart disease – CHF" as an underlying cause of death and "pneumoconiosis; diabetes; pacemaker" as other significant conditions contributing to but not resulting in the underlying cause of death. A death certificate, by itself, is an unreliable report of a miner's condition at the time of his death when the record provides no indication that the individual signing the death certificate possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death. *See Smith v. Camco Mining, Inc.*, 13 B.L.R. 1-17 (1989); *Addison v. Director, OWCP*, 11 B.L.R. 1-68 (1988). The record fails to show that Dr. Hurst physically examined the Miner. His credentials are not of record. Dr. Hurst gave no basis for his finding that pneumoconiosis contributed to the Miner's death. Accordingly, I find his opinion to be conclusory and entitled to little weight.

Dr. Givens treated the Miner from 1971 until his death in 1990, including two periods of hospitalization in 1990. The

Miner was admitted to Muhlenberg Hospital in February and March 1990 with complaints of shortness of breath and chest pain. He was treated and tests were conducted with respect to the Miner's congestive heart failure. The March 21, 1990 admission report notes a "history" of pneumoconiosis. The March 27, 1990 Discharge Summary states that death was due to: (1) acute myocardial infarction with cardiac arrest; (2) coal workers' pneumoconiosis; and, (3) adult onset diabetes mellitus. In a letter dated October 21, 1998, Dr. Givens stated that throughout his treatment of the Miner, he "was known to have and was treated for pneumoconiosis." He opined that "the work load on his heart was aggravated by his pulmonary condition. In my opinion, pneumoconiosis was a contributing factor in his death." In a letter dated July 18, 2000, Dr. Givens opined that the Miner suffered from chronic obstructive pulmonary disease. He noted that no pulmonary function studies were performed in the latter part of the Miner's life and that all of his own office notes pertain to the Miner's cardiac condition.

Although Dr. Givens was the Miner's treating physician, he failed to give any basis for his opinion as to the presence of pneumoconiosis or cause of death. While I have found the existence of pneumoconiosis based on the x-ray evidence, the record does not show that Dr. Givens interpreted any x-rays. He noted a "history" of pneumoconiosis in March 1990 and found that pneumoconiosis was a cause of death, however, he did not diagnose pneumoconiosis in any reports of record. "History" of pneumoconiosis is an insufficient basis upon which to either make a diagnosis of pneumoconiosis or a finding that death was caused by pneumoconiosis. Dr. Givens stated in the July 2000 letter that the Miner suffered from COPD. Again, he did not state upon what evidence he relied in making this diagnosis. Further, the pulmonary function and arterial blood gas study evidence of record fails to show any respiratory impairment. The record fails to show that the Miner took medication for any respiratory impairment. Dr. Givens' opinion is conclusory, unreasoned, undocumented, and unsupported by the evidence. It is entitled to little weight.

Dr. Jarboe issued a consultative report dated August 3, 2000 and was deposed on August 14, 2000. Dr. Jarboe opined that the evidence supports a finding of pneumoconiosis but not of a respiratory impairment. He said that pneumoconiosis did not have any significant effect on the Miner's condition prior to his death because "to have done so, pneumoconiosis would have to have affected his ventilatory function or gas exchange." Although Dr. Givens said that he treated the Miner for pneumoconiosis and COPD, Dr. Jarboe noted that the Miner was

never given any medication for a respiratory impairment and that no objective tests show COPD. Dr. Jarboe stated that congestive heart failure can cause air flow obstruction and that patients with congestive heart failure can be confused with patients who have COPD. Dr. Jarboe concluded that the Miner died from cardiac disease and that the record fails to support any causal connection between the Miner's death and exposure to coal dust.

Dr. Branscomb issued a consultative report on May 11, 2000, at which time he stated that the evidence, including objective test results, supports a finding of pneumoconiosis but not of respiratory impairment. He opined that pneumoconiosis had no impact on the Miner's death and that the Miner would have died in the same way and at the same time "had he never stepped foot in a coal mine." At the August 15, 2000 deposition, Dr. Branscomb stated that the Miner had severe cardiac problems for many years and died as a result of that condition. He noted that the Miner's symptoms were consistent with heart disease and not with a respiratory impairment. Dr. Branscomb opined that pneumoconiosis did not contribute to the Miner's death based on normal pulmonary function and arterial blood gas testing and no evidence of cor pulmonale.

Dr. Dahhan issued a consultative report dated June 22, 1999. He opined, based on x-ray evidence, that the Miner did not suffer from pneumoconiosis. He said that the Miner was totally disabled at the time of his death due to congestive heart failure but suffered no pulmonary disability. The Miner's death was due to a heart attack complicating a previous heart attack and coronary artery disease, conditions of the public at large and not attributable to coal dust exposure. In a supplemental report dated April 7, 2000, Dr. Dahhan stated that although the more recent x-ray evidence is inconsistent with pneumoconiosis, earlier x-rays are consistent with the disease. He concluded that if the Miner suffered from pneumoconiosis, the objective evidence fails to show that he suffered from any pulmonary impairment as a result of that condition. Because there is no evidence of a functional respiratory impairment, Dr. Dahhan opined that pneumoconiosis did not contribute to the Miner's death, which was due to a heart attack and would have occurred regardless of the Miner's coal dust exposure. Dr. Dahhan noted that the Miner's heart failure was on the left side, a condition not seen in patients who develop heart failure secondary to coal dust exposure.

Dr. Morgan issued a consultative report dated July 16, 1999 and opined that the Miner may have had some minimal pneumoconiosis but he died as a result of a myocardial

infarction, “which had no relationship to his former occupation of coal mining, and coal dust played no role in his death.” He noted a strong family history of cardiac disease and that the Miner’s symptoms were consistent with congestive heart failure. Dr. Morgan reiterated his opinion in a supplemental report dated April 17, 2000. “It is quite clear that Mr. Perry was disabled for two to three years with congestive failure and heart disease and that his disability developed after 1983 and was clearly a consequence of his heart disease and was unrelated to his former job as a miner.” Dr. Morgan concluded that coal dust failed to contribute to the Miner’s disability or demise. At the August 18, 2000 deposition, Dr. Morgan noted that the Miner’s health had “always been good,” according to the Miner, prior to the myocardial infarction in 1982, that the Miner did not take medication for any respiratory problems, and that he did not complain of cough or sputum after ceasing coal mine employment. He disagreed with Dr. Givens that a pulmonary impairment contributed to the Miner’s cardiac condition.

The opinions of Drs. Jarboe, Branscomb, Dahhan, and Morgan are well reasoned, well documented, and are supported by the objective medical evidence. Although they did not physically examine the Miner, they based their opinions on numerous medical records, including the Death Certificate, medical reports, objective tests, and x-rays dated between 1979 and 1990. They are highly qualified physicians and their opinions are entitled to substantial weight.

Dr. Zaldivar issued a consultative report dated August 3, 2000. He opined that there is insufficient evidence to justify a diagnosis of pneumoconiosis or that the Miner suffered from any pulmonary impairment. Because the Miner did not suffer from pneumoconiosis, Dr. Zaldivar opined that it could not have caused his death. In addition, the Miner “died a cardiac death due to arteriosclerotic vascular disease which had caused him to have three heart attacks, the last one of which was terminal.” He concluded that pneumoconiosis did not contribute to the Miner’s death and he “would have died when and as he did even if he had never worked in the coal mines.” As stated, I have found the existence of pneumoconiosis based on the x-ray evidence. Because Dr. Zaldivar based his finding as to cause of death in part on the absence of pneumoconiosis, I find that his opinion on this issue is entitled to less weight than those of Drs. Jarboe, Branscomb, Morgan, and Dahhan.

Drs. Hurst and Givens opined that the Miner’s death was due in part to pneumoconiosis. I have given little weight to their opinions, however, because they are conclusory, unreasoned, and

un-supported by the evidence. The opinions of Drs. Jarboe, Branscomb, Morgan, and Dahhan are better reasoned and better supported by the objective evidence. I place greater weight on their opinions and find that the medical opinion evidence fails to support a finding of death due to pneumoconiosis.

Under § 718.304, there is an irrebuttable presumption of death due to pneumoconiosis when complicated pneumoconiosis is established. In the September 26, 1983 Decision and Order, I found that complicated pneumoconiosis was not established. This finding was affirmed by the Board in its February 28, 1986 Decision and Order. As no new evidence of complicated pneumoconiosis has been submitted, I find that the Claimant has failed to show that the Miner suffered from complicated pneumoconiosis.

VI. ENTITLEMENT

The Claimant has failed to establish that the Miner's death was due to pneumoconiosis. Therefore, the Claimant has failed to establish entitlement to benefits under the Act.

VII. ATTORNEY'S FEES

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

VIII. ORDER

It is, therefore,

ORDERED that the claim of Mary Ann Perry for benefits under the Act is hereby DENIED.

ROBERT L. HILLYARD
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits

Review Board at P.O. Box 37601, Washington, D.C., 20013-7601. A copy of the Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C., 20210.